Request for Family & Medical Leave

This form is to be used when you need to request family and medical leave. FMLA provides up to 12 weeks on an annual basis of unpaid, job-protected leave to eligible employees for certain family and medical reasons. When circumstances permit, you should notify the HR office at least 30 days in advance of your need to take family and medical leave.

INSTRUCTIONS TO COMPLETE FORM:

- Complete the information requested in the first section.
- Read each of the statements regarding Family & Medical Leave.
- Contact the HR Manager if you do not understand any of the statements and/or need further assistance in completing the form.
- Check the box if you wish to substitute accrued paid leave for unpaid leave. If you choose this option, it is your responsibility to contact the HR Manager to determine what your current leave balances are and to discuss how much paid leave to substitute.
- Sign and date the form on the lines provided.
- Return to the HR Office for authorization.

Once your request has been reviewed, you will receive an Employer Response Form by certified mail authorizing your request. The form will include specific details with regard to your leave including the expected begin and end dates.

You are given 15 days to return the Certificate of Health Care Provider Form (if required). If this form is not received in a timely manner, our agency may delay the commencement of your leave until the form is submitted.

Certificate of Health Care Provider Form:

This form should be given to your health care provider to complete in regards to the serious health condition, supporting medical facts, period of incapacity, chronic condition, medical treatments, etc.

INSTRUCTIONS TO COMPLETE FORM:

- Your health care provider should complete pages 1, 2, and 3 of the form.
- The physician must sign and date the form on page 3 and include address information.
- The employee must sign and date the form at the bottom of page 3 on the lines provided.
- If the employee is taking family and medical leave to care for a family member, please provide the requested information on page 3. Be sure to include your projected work schedule if leave will be taken intermittently.

If required, this form should be returned to the Human Resources Office within 15 days of receipt. If the form is not received in a timely manner, our agency may delay the commencement of your leave until the form has been submitted.

The form can be faxed to the HR office at (501) 683-4080 or mailed to Arkansas Secretary of State Office, Attn: Human Resources Manager, Room 012, State Capitol Building, Little Rock, AR 72201.

Your Rights
Under The
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons For Taking Leave

Unpaid leave must be granted for any of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide thirty (30) days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA;
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supercede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
June 1993

Arkansas Secretary of State

Human Resources Office

Request for Family and Medical Leave Form

Please complete the following information:

Employee Name	
Personnel Number	
Begin Date for FMLA	
End Date for FMLA	
Department	

Please read each of the following statements regarding FMLA Leave:

- I am requesting Family and Medical Leave for the days indicated above.
- I understand that when applicable, I should notify my employer of my intent to take leave at least 30 days prior to the begin date for FMLA.
- I understand that FMLA, as federally mandated, is unpaid leave, and that I may substitute accrued paid leave for all or some portion of the leave.
- I understand that the Human Resources Office may require a written second opinion from a health care provider at the expense of the state.
- I understand, if approved, that during FMLA, the agency will continue paying the employer portion of my group health plan, if I am a participant.
- I understand that I am responsible for paying the employee's portion for the health plan for each pay period. If I do not pay, my health plan may be cancelled after 30 days.
- Employee Benefits Division may contact my Health Care Provider for clarification/authenticity of my medical certification if required.

☐ Yes, I am requesting to substitute my accrued paid leave for unpaid leave. I agree to contact the Human Resources Manager to determine what my current leave balances are and to discuss how much accrued paid leave to substitute.

_____ _____

Employee Signature Date

AUTHORIZATION:

_____ _____

Human Resources Manager Date Received

☐ Request for Family & Medical Leave Approved

☐ Request for Family & Medical Leave Disapproved

OPM 007

State of Arkansas
Certificate of Health Care Provider
(Family and Medical Leave Act of 1993)

1. Employee's Name	2. Patient's Name (if different from employee):

3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1)☐ (2)☐ (3)☐ (4)☐ (5)☐ (6)☐

Or None of the above ☐

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories.

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**[2], if different):

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)? ☐ Yes ☐ No

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:

6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health/services** (e.g., physical therapist) please state the nature of the treatments.

c. If **a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform** work of any kind?

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions?

If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for the basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider	Type of Practice	
Address	Telephone Number	Date

This section to be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

Employee's Signature	Date

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment
   a. A period of incapacity[2] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

      (1) Treatment[3] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

      (2) Treatment[3] by a health care provider on at least one occasion which results in a regimen of continuing treatment[4] under the supervision of the health care provider.

3. Pregnancy
   Any period of incapacity[2] due to pregnancy or prenatal care.

4. Chronic Conditions Requiring Treatments
   a. A chronic condition which
      (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

      (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

      (3) May cause episodic rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision
   A period of incapacity[2] which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)
   Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or a condition that would likely result in a period of incapacity[2] more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis.)

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[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.

[4] A regimen of continuing treatment includes for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.